ATTACHMENT A
Procedure for Continuity of
Prior Authorized Services for Adults
TRANSITION FROM FEE-FOR-SERVICE TO A MANAGED CARE ORGANIZATION

*****REMINDER: Providers must check the Eligibility Verification System (EVS) prior to providing any service to an eligible Medical Assistance (M A) recipient and must listen to the entire EVS message in order to obtain the correct eligibility information necessary for payment.**

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1. If the recipient/enrollee is covered by M A fee-for-service (FFS) and the M A enrolled treating provider successfully requests from the Department of Public Welfare (Department) a prior authorization for services, "from" and "to" dates are assigned by the Department and entered in the Prior Authorization subsystem. If a provider learns, through EVS or otherwise, that a recipient/enrollee with an approved FFS prior authorization number, has enrolled in a managed care organization (MCO), the provider must call the MCO and notify them of the prior authorized services about to be performed.

2. When the MCO is contacted, the MCO must check the Department's Prior Authorization subsystem to determine if the recipient/enrollee has a prior authorization number on file. If yes, the MCO must either:

   A) Approve the service and honor the amount, duration/frequency and scope of services (for up to sixty (60) days) at the recipient's/enrollee's option, as specified by the approved prior authorization;

   OR

   B) Approve the amount, duration/frequency and scope of services (at the recipient's/enrollee's option) **pending a concurrent clinical review** of the continued need for the Department's prior authorized services. **Under no circumstances may the MCO withhold authorization to continue the services, reduce, delay or interrupt the receipt of the services prior to the MCOs concurrent clinical review.**

   If, as a result of the concurrent clinical review the MCO authorizes an alternative course of treatment, a reduction, or termination of the Department's approved prior authorization, the MCO must provide proper written notification of the changes to the recipient/enrollee and the prescribing provider and honor the recipient's/enrollee's right to exercise his/her full grievance and fair hearing rights.

   If the recipient/enrollee has been receiving the services that are being reduced, changed, or denied and they file a grievance or request a fair hearing that is hand delivered or postmarked within ten days of the date of the written notice of decision, the services will continue until the grievance or fair hearing decision is made.

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3.A. If the provider is not a participating provider in the MCO, the MCO may recruit the provider as a participating provider or arrange for the service to be delivered by a participating provider, if the recipient /enrollee consents to the change in providers. Should the recipient /enrollee wish to continue to receive services from their non-participating M A provider, they shall be granted approval of a transitional period of up to sixty (60) days from the effective date of enrollment with the MCO. The MCO, in consultation with the recipient/enrollee and the health care provider, may extend this transitional period if determined to be clinically appropriate.

- In the case where a new (and pregnant) enrollee is already receiving care from an out of network OB-GYN Specialist at the time of enrollment, the member may continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery.

3.B. If the non-participating M A provider does not wish to enroll in the MCO and a transfer to a participating provider is clinically contraindicated for any reason including the beneficial therapeutic relationship or in the case that the recipient/enrollee does not wish to change providers at this time, the MCO shall approve the service out-of-network, come to mutually acceptable terms on an appropriate rate and advise the provider of the MCO's procedures for billing. The provider delivers the service to the recipient/enrollee, and does not invoice the Department but invoices the MCO according to their billing procedures.

4. If the MCO provider or the non-participating M A provider proposes to continue the prior authorized service, a request must be submitted to the MCO in sufficient time prior to the end of the approval period to allow the MCO adequate time to reassess the need for service and make a determination of medical necessity ten days before the end of the previously approved period. If the MCO decides to deny the request either in full or by authorizing a change in amount or duration of services, or alternative services, the MCO must notify the recipient/enrollee and the prescribing provider in writing at least ten days in advance of the effective date of the proposed change in authorization. In such cases, the recipient/enrollee is entitled to exercise his/her full range of grievance and fair hearing options.

- Any health care service provided by non-participating M A providers under continuity of prior authorized service provisions shall be covered by the MCO under the same

terms and conditions as applicable for participating health care providers. MCOs shall not be required to provide health care services that are not otherwise covered under the terms and conditions of the MCO.

- In the case where a new (and pregnant) enrollee is already receiving care from an out of network OB-GYN Specialist at the time of enrollment, the member may continue to receive services from that specialist throughout the pregnancy and postpartum care related to the delivery.